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Editorial

# Social Stigmatization of People living with HIV

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## ABSTRACT

People from rural Nepal struggle to get essential health services due to geographical and economic barriers. There is still a lack of awareness and stigmatization of people living with HIV in countries with poor socioeconomic status like Nepal. According to the National AIDS and STI Control Center (NCASC) factsheet 2020, there are more than 2900 PLHIV in Nepal. One-third of them are still not under treatment. There are still many incidents of social stigma and discrimination associated with PLHIV. I present a case of 20 years old male with a diagnosis of HIV responding well with ante retroviral therapy who committed suicide due to social isolation, stigma, and discrimination.

**Key Words:** Social Stigmatization, Ante Retroviral Therapy, People living with HIV, Acquired Immno Deficiency Syndrome, Sexually Transmitted Disease, Sexually Transmitted Illness.

## INTRODUCTION

AIDS is a chronic disease and potentially life-threatening condition that HIV causes. Infection with the virus results in the progressive weakening of the immune system, which leads to immune deficiency.1 HIV-related stigma and discrimination are highly prevalent across the globe.2 Gaps across the HIV prevention, testing, and treatment services are aggravated by stigma and discrimination faced by PLHIV and people at high risk of HIV infection.

## DISCUSSION

The after-mentioned case reflects the social viewpoints towards PLHIV in the rural part of Nepal. Although we conducted an awareness campaign with all the stakeholders, it was not enough to prevent such a sad event.

A study done in Pokhara, Nepal, showed that a majority (83.3%) of adult PLHIV had a high level of Public Attitude Concern, followed by Disclosure Concern 68.1% and Negative Self Image 59.9%. In contrast, only 25.4% of adult PLHIV had a higher level of Enacted Stigma. It showed that fear of being stigmatized is more than actual stigma experience.8 A study done in Indonesia showed that PLHIV faced problems like separation of personal belongings such as clothes and eating utensils from those of other family members, separation from children, and being asked to stay away from home or live in different places. Those were some instances of discriminatory and stigmatizing attitudes and behaviors of family members towards them. It also showed that social perceptions that associated HIV infection with perceived negative behaviors (e.g., sex with multiple sex partners and engagement in non-marital sexual relations) were the driving factors for stigma and discrimination toward PLHIV. 9

## WAY FORWARD

This suggests a high level of felt stigma, which has devastating effects on PLHIV and leads to nondisclosure of seropositive status and another harmful effect, even death. So, considering the significant impact of felt stigma on control of the HIV epidemic, it is important to have a comprehensive multidisciplinary approach towards PLHIV via timely intervention like better educational intervention and counseling to PLHIV, wide-scale societal awareness campaigns, and more focused local interventions.

3 Studies on stigma and discrimination and health-seeking behavior show that people living with HIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay in reaching care until they are very ill.Furthermore, it is a disease that probably brings separation among families, triggering a compassionate, solidarity response.5 So, addressing stigma affecting people living with HIV/AIDS (PLWHA) is a global priority.6 Stigmatization leads to self-blame, shame, lack of disclosure, reduced self-confidence, loss of motivation, withdrawal from social contact and health-based interactions, and abandonment of planning for the future.7 Here, I present a case of PLHIV facing social stigmatization.

## CASE REPORT

Twenty years old male patient visited our OPD with the chief complaint of severe epigastric pain for two months with a treatment history with PPI and antacid gel from a local medical shop with an occupational history of foreign employment with no other significant history and physical examination findings. Initial investigations including CBC, ESR, H. Pylori, Amylase, USG (abdomen and pelvic), and stool for occult blood were normal. The patient was advised for dietary control, Proton Pump Inhibitor (PPI) and medical consultation for endoscopy evaluation. The endoscopic findings were negative for ulcerative lesions and suspected malignancy. The patient was then advised to continue PPI and follow up in three months. On follow-up, he was advised for serological evaluation for HIV and hepatitis as there was persistent epigastric pain. HIV test results came positive on determine, stetback, and unigold test kit as recommended by NSASC.

He was then sent to an ART counseling session and was counseled about his seropositive status. He was initially in the denial phase. He was explained about the detailed lab procedure and its sensitivity. He requested reconfirmation. We repeated the test in front of him and showed him the test result, and he was in tears. We spent quality time with him explaining the disease condition, current treatment protocol, disease progression, and all the necessary steps to be taken. He denied any unsafe sexual contact other than with his wife, but he gave a history of blood transfusion in Malaysia following a road traffic accident.

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He was immediately started with anti-retroviral therapy. Dried blood samples for DNA-PCR and CD4 count were sent. We advised him to follow up with his wife in a week and use a condom for dual protection. He came back along with his wife in one week. The test result of his wife was negative. We disclosed his seropositive status to his wife with his consent. She was convinced and was ready to support her husband during treatment. We made arrangements to meet with other seropositive patients. They were already on medicine for more than ten years. He was happy to know that HIV-positive can live life longer than he expected and do well. He was advised to follow up in the next three months. He came back in three months with his wife and tolerated ARV drugs well. There were no new issues. We advised him to visit the community care unit for HIV (CCU) for emotional support and to engage in social activity. He was doing well and was on regular follow-up. His recent CD4 count was 700, with a viral load of 1000 copies.

On one of the busy days at OPD, our ART counselor came up with him and requested me to spend some time with him as he was anxious; I went to the counseling room with him. He was in tears as he said his relatives and other community member knew about his HIV-positive status and started neglecting him in all social and ritual activities. We assured him we would take care of that situation and advised him to stay at the community care unit near the hospital for some time. We contacted ward chairpersons for his rural municipality. He assured us that he would take care of the situation. Two promotional campaigns were conducted for one month in the initiation of the ward office. He returned to his village nearly two months after his stay at CCU. He was on regular follow-up, but he was still not convinced by social attitude toward him. He used to state that people are still negative toward him. We examined him for psychological status (mental status examination). He denies having a low mood or any thought problems. We had repeated counseling sessions with him in the last six months. He was doing quite well. I still remember his saying, Society is still not accepting me. We always encouraged him to stay positive and be the change. I got a call from the police early in the morning on one of the lazy Saturdays stating there was one postmortem case of hanging. I went to the postmortem room and was shocked to see that guy on post mortem bed. That was not supposed to be the end. He ended his life, not due to HIV but associated stigmatization in Society.

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